

Mail completed copy to:

Department of Labor and Industry  
PO Box 64221  
St. Paul, MN 55164-0221  
(651) 284-5030 or  
1-800-342-5354 (DIAL-DLI)

# Rehabilitation Consultation Report

Enter dates in MM/DD/YYYY format.



DO NOT USE THIS SPACE

1. WID or SSN		2. DATE OF INJURY			
3. EMPLOYEE NAME					
4. EMPLOYEE ADDRESS					
CITY		STATE	ZIP CODE	5. EMPLOYEE PHONE #	
6. EMPLOYER NAME			7. EMPLOYER CONTACT PERSON		8. ER PHONE #
9. INSURER CLAIM NUMBER			14. QRC NAME		
10. INSURER/SELF-INSURER/TPA			15. QRC FIRM		
11. INSURER ADDRESS			16. QRC ADDRESS		
CITY		STATE	ZIP CODE	CITY	STATE ZIP CODE
12. CLAIM REPRESENTATIVE		13. CLAIM REP PHONE #		17. QRC #	18. QRC FIRM # 19. QRC PHONE #
20. Is the employee permanently precluded or likely to be permanently precluded from engaging in the employee's usual and customary occupation or from engaging in the job the employee held at the time of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No					
21. Can the employee reasonably be expected to return to suitable gainful employment with the date-of-injury employer? <input type="checkbox"/> Yes <input type="checkbox"/> No					
22. Can the employee reasonably be expected to return to suitable gainful employment through the provision of rehabilitation services, considering the treating physician's opinion of the employee's work ability? <input type="checkbox"/> Yes <input type="checkbox"/> No					
23. I have consulted with the date-of-injury employer regarding the above issues. <input type="checkbox"/> Yes <input type="checkbox"/> No					
24. Check Box A, B or C as applicable: <input type="checkbox"/> A. It is my opinion that the employee is a qualified employee and eligible for rehabilitation services at this time according to Minn. Rules 5220.0100, subp. 22. <input type="checkbox"/> B. It is my opinion that the employee is not a qualified employee and is not eligible to receive rehabilitation services at this time according to Minn. Rules 5220.0100, subp. 22. <input type="checkbox"/> C. The parties have informed me that they wish to initiate statutory rehabilitation services at this time.					
ATTACH A NARRATIVE REPORT EXPLAINING THE BASIS FOR YOUR DETERMINATION					
25. Date of rehabilitation consultation		QRC Signature		QRC Intern Signature (if applicable)	

**QRC:** File this form with the Department of Labor and Industry within 14 days of date in Box 25 (the first in-person meeting or the first telephone conference) as required by Minn. Rule 5220.0130. If the employee is eligible for rehabilitation services, a Rehabilitation Plan (R-2) must be developed and circulated to the parties within 30 days of the initial meeting and filed with the Department within 45 days of the initial meeting as required by Minn. Rule 5220.0410.

**Employee:** If you disagree with or have questions about the information provided on this form, you are encouraged to contact the QRC and insurer to discuss any concerns. If your concerns are not resolved, you may call the Department's Benefit Management and Resolution Unit at (651) 284-5032 or 1-800-342-5354 or request a determination by filing a Rehabilitation Request with the Department.

**This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/Voice or TDD (651) 297-4198.**

**ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.**